



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NEUROMUSCULAR INSTITUTE OF TEXAS PA
9502 COMPUTER DR STE 100
SAN ANTONIO TX 78229-2025

Respondent Name

TWIN CITY FIRE INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M5-06-2161-01

MFDR Date Received

May 3, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred to WC program on 4/24/03 by the treating doctor, Dr. Burdin, DC in conjunction with a referral to PMR, DO. The patient was seen on 5/13/03 by Dr. Hirsch, PMR DO for office visit where 6 injections were given and a prescription for 7 OT sessions. DOS 6/24/03 the patient met with Dr. Hirsch, PMR, DO for 2nd set of injections and 7 OT sessions were prescribed. DOS 7/13/03 was for assessment of MMI and re-exam by the treating doctor where TWCC forms were filed in compliance with rules and guidelines. Dos 9/12/03 was for an office visit with the treating doctor and a 73 was completed per TWCC requirements."

Amount in Dispute: \$15.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is Carrier's contention that Neuromuscular Institute did not properly request for reconsideration in accordance with Chapter 133.304 (k) (3), they did not send a request for reconsideration and failed to resubmit the exact bill as required. . . . The medical treatment was reviewed via peer review and found not to be reasonable or necessary and originally denied."

Response Submitted by: The Hartford, Houston Workers' Compensation Claims Center, PO Box 4626, Houston, Texas 77210-4626

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2003 to September 12, 2003	Professional Medical Services	\$1,599.00	\$610.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out general provisions related to medical fee disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §133.308 sets out the procedures for review of medical necessity disputes.
4. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
5. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services.
6. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a benefit review conference.
7. 28 Texas Administrative Code §180.22 establishes the roles and responsibilities of health care providers.
8. Texas Labor Code §408.021 sets forth provisions regarding entitlement to medical benefits.
9. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
10. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 7, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
11. Disputed procedure code 99080-73, dates of service July 16, 2003 and September 12, 2003, were withdrawn by the requestor by letter of request dated May 16, 2007. These services are no longer in dispute and are not addressed in this review.
12. Disputed procedure codes E0230, service date June 24, 2203, and 99213, service date September 12, 2003, were withdrawn by the requestor by letter of request dated November 2, 2006. These services are no longer in dispute and are not addressed in this review.
13. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - V – PAYMENT WITHHELD AS PEER REVIEW INDICATES DOCUMENTATION DOES NOT SUPPORT THE TREATMENT TO BE MEDICALLY REASONABLE AND/OR NECESSARY.
 - V – PAYMENT WITHHELD AS PEER REVIEW INDICATES DOCUMENTATION DOES NOT SUPPORT THE TREATMENT TO BE MEDICALLY REASONABLE AND/OR NECESSARY. SUBMITTED DOCUMENTATION DOES NOT SUPPORT REIMBURSEMENT FOR PHYSICIAN/ENTITY NOTED IN BOX 31 OF THE HCFA.
 - F – REIMBURSED ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.
 - A – PRE-AUTHORIZATION NOT OBTAINED.
 - L – NOT TREATING DOCTOR
 - R – REIMBURSEMENT WITHHELD – CHARGE UNRELATED TO COMPENSABLE INJURY.

Issues

1. Are there unresolved issues related to the medical necessity of the disputed services?
2. Were the disputed services approved or recommended by the injured employee's treating doctor?
3. Did the requestor submit the request for medical dispute resolution in the form, format, and manner prescribed by the Division?
4. Are there unresolved issues related to compensability, extent or liability for the disputed health care?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services, including procedure code 99455-4P, service date July 16, 2003, with payment exception code V – "PAYMENT WITHHELD AS PEER REVIEW INDICATES DOCUMENTATION DOES NOT SUPPORT THE TREATMENT TO BE MEDICALLY REASONABLE AND/OR NECESSARY" and "PAYMENT WITHHELD AS PEER REVIEW INDICATES DOCUMENTATION DOES NOT SUPPORT THE TREATMENT TO BE MEDICALLY REASONABLE AND/OR NECESSARY. SUBMITTED DOCUMENTATION DOES NOT SUPPORT REIMBURSEMENT FOR PHYSICIAN/ENTITY NOTED IN BOX 31 OF THE HCFA." Per former rule at 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282 "Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care." Per §133.305(b) "If there is a medical necessity dispute for which there are medical fee components, the requestor shall file a request for medical dispute resolution with the commission. The medical necessity dispute will be resolved pursuant to §133.308 of this title prior to deciding the medical fee dispute pursuant to §133.307 of this title. Per former rule at 28 Texas Administrative Code §133.307(a) Medical necessity is not an issue in a medical fee dispute. Review of the submitted information finds that the disputed medical necessity issues were submitted to an independent review organization for resolution according to §133.308 procedures. A notice of independent review decision (as amended) was issued on May 23, 2007 upholding the determination of the carrier. The Division therefore finds that there are no longer any pending issues of medical necessity related to the disputed services. The insurance carrier's above denial reasons are supported. Reimbursement for these services cannot be recommended.

2. The insurance carrier denied disputed services for date of service May 13, 2003 with payment exception code L – “NOT TREATING DOCTOR.” Per former Division rule at 28 Texas Administrative Code §180.22(c), effective March 14, 2002, 27 *Texas Register* 1817, “The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care rendered to the employee.” Additionally, Texas labor Code §408.021(c) requires that “Except in an emergency, all health care must be approved or recommended by the employee’s treating doctor.” Review of the submitted information found no documentation to support that the disputed services were approved or recommended by the injured employee’s treating doctor. The insurance carrier’s denial reason is supported. Reimbursement for these services cannot be recommended.
3. Former version of Division rule 28 Texas Administrative Code §133.307(e), effective January 1, 2003, 27 *Texas Register* 12282, requires that “All provider and carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission [now the Division]. . . . (2) Each copy of the request . . . shall include: . . . (B) a copy of each explanation of benefits (EOB) or response to the refund request relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB.” Review of the submitted documentation finds that the request does not include a copy of any explanations of benefits regarding procedure code 99211, service date June 24, 2003. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The requestor has not filed the request in the form, format, and manner prescribed by the Division. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B). The requestor has the burden of proof in this matter. Based on the submitted documentation, the Division finds insufficient information to make a determination as to the fee issues regarding this disputed service. The requestor has failed to support that additional reimbursement is due. No additional reimbursement can be recommended for this disputed service.
4. The insurance carrier denied disputed services with payment exception code R – “REIMBURSEMENT WITHHELD – CHARGE UNRELATED TO COMPENSABLE INJURY.” Former 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, defines a medical fee dispute as a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee’s compensable injury. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires the filing of a request for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 to resolve any such issues prior to requesting medical fee dispute resolution. Review of the submitted documentation and Division records finds that a contested case hearing was held to decide pending issues of compensability or disability, with a decision issued on March 4, 2002, finding, in pertinent part, that “Claimant sustained a compensable injury. . . The compensable injury extends to both the right eye and the back. Claimant has had disability . . . through the date of this hearing.” The submitted documentation supports that the issues of compensability have been resolved prior to the filing of the request for medical fee dispute resolution. The insurance carrier was further ordered to pay medical benefits in accordance with the above decision. This denial reasons is not supported. These disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
5. This dispute relates to professional medical services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202, effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Per §134.202(c), “To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers’ compensation system is the effective conversion factor adopted by CMS multiplied by 125%.” Reimbursement for disputed date of service June 24, 2014, is calculated as follows:
 - The Medicare reimbursement for procedure code 20550 is \$53.36. This amount multiplied by 8 units is \$426.88. This amount multiplied by 125% results in a MAR of \$533.60. This amount is recommended.
 - The Medicare reimbursement for procedure code 97110 is \$26.11. This amount multiplied by 125% results in a MAR of \$32.64. This amount is recommended.
 - The Medicare reimbursement for procedure code 97124 is \$20.56. This amount multiplied by 125% results in a MAR of \$25.70. This amount is recommended.
 - The Medicare reimbursement for procedure code 97139-ME is \$14.61. This amount multiplied by 125% results in a MAR of \$18.26. This amount is recommended.

- Procedure code J3490 represents a service for which CMS or the Division does not establish a relative value unit and/or a payment amount. Per §134.202(c)(6), “for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.” No documentation was found to support that the insurance carrier has assigned a relative value or payment amount for this disputed service. Consequently, reimbursement is determined according to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.” Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the documentation submitted by the requestor finds that the requestor did not discuss, demonstrate, or justify that the payment amount sought is a fair and reasonable rate of reimbursement for procedure code J3490. The requestor has failed to establish that additional reimbursement is due for this disputed service. Additional reimbursement cannot be recommended.

The total recommended reimbursement for the services in disputed is \$610.20. The insurance carrier paid \$0.00, leaving a remaining balance due to the requestor of \$610.20. This amount is recommended.

Conclusion

For the reasons stated above, the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$610.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$610.20, plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

February 26, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.